# Family Care Audit Guide

**CFDA # 93.778**

***A supplement to the Provider Agency Audit Guide and to the State Single Audit Guidelines for Resource Centers and Care Management Organizations participating in the Family Care Program***


**2002 Revision**

# Family Care Audit Guide
# 2002 Revision

## Summary of changes in this revision

| Section | | Description of changes |
|---|---|---|
| 1.3 | Entities operated by local governments | • Modified references to major and Type A programs to match definitions used in current DHFS Appendix to the *State Single Audit Guidelines* |
| 1.4 | Effective date | • Noted that the 2002 revision is effective for years ending on or after 12/31/02. |
| 1.9 | Questions on audit requirements | • Changed contact person. |
| 2.2 | Medical cost center for information and assistance activities | • Added audit procedure for checking expenses reported to the department for reimbursement. |
| 2.3 | Functional screen federal financial participation (FFP) | • Added audit procedure for checking expenses reported to the department for reimbursement. |
| 3.7 | Capacity for financial solvency and stability | • Modified audit requirements to reflect three components for financial capacity in 2002 contracts: working capital, restricted reserve, and solvency protection. |

# Family Care Audit Guide
# 2002 Revision

*A supplement to the Provider Agency Audit Guide and to the State Single Audit Guidelines for Resource Centers and Care Management Organizations participating in the Family Care Program*

## Forward

This audit guide covers audit requirements for Resource Centers and Care Management Organizations participating in Family Care.

The following overview of Family Care is from the department's website at http://www.dhfs.state.wi.us/LTCare/INDEX.HTM:

Family Care is a flexible long term care (LTC) benefit authorized by 1999 Wisconsin Act 9. The goals of Family Care are to increase consumer choice, improve access to services, create a comprehensive and flexible long term care service system, improve quality through a focus on health and social outcomes, and create a cost effective system for the future.

Family Care will foster recipients' independence and quality of life, while recognizing the need for interdependence and support. This major redesign of the state's long term care system has three major components:

- Aging and Disability Resource Centers, where older people and people with disabilities and their families can get information and advice about a wide range of resources available to them in their local communities.
- The Family Care benefit, which combines funding from a variety of existing programs into one flexible long term care benefit covering a wide variety of services and supports, tailored to each individual's needs, circumstances and preferences.
- Care Management Organizations (CMOs), which will manage and deliver the new Family Care benefit.

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# Family Care Audit Guide
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*A supplement to the Provider Agency Audit Guide and to the State Single Audit Guidelines for Resource Centers and Care Management Organizations participating in the Family Care Program*

## 1 Introduction

In this document,

*Care Management Organization* means an organization that has been certified by the department to make available to members, in consideration of periodic fixed payments, certain long term care and health care services. Under the terms of the risk-based Health and Community Supports Contract, the CMO receives a prospective payment for each member and is responsible for performing comprehensive assessments, developing interdisciplinary care plans, delivering services either directly or through contracted providers, and monitoring consumer outcomes.

*Department* means the Wisconsin Department of Health and Family Services.

*Resource Center* means an entity under contract to the department to provide services specified in its contract with the department. Resource Centers provide "one stop shopping" for information about and assistance accessing the long term care system. They are also charged with performing Pre-Admission Consultation to individuals entering the long term care system via residential settings, to assist these individuals in making informed and cost-effective decisions about meeting their long term care needs. Resource Centers also determine functional eligibility for the Family Care benefit available from CMOs and enroll eligible individuals in the CMO.

*Service Provider* means an entity under contract to the Care Management Organization to provide specified services to members of the Care Management Organization.

### *1.1 Applicable audit standards*

Audits of agencies participating in the Family Care Program shall be performed in accordance with the following standards:

1. Generally accepted auditing standards, established by the American Institute of Certified Public Accountants, including consideration of fraud. See Chapter 6 of the *Provider Agency Audit Guide* for guidance on consideration of fraud in a government contract environment.

2. *Government Auditing Standards*, established by the United States General Accounting Office.

3. The department's audit standards in:

a. The *State Single Audit Guidelines* for audits of local governments which are in accordance with OMB Circular A-133 "Audits of States, Local Governments, and Non-Profit Organizations" based on other funding received by the agency (see Section 1.2). (Contact Document Sales at (608) 266-3358 for information on purchasing the *Guidelines*.)

or

b. The standards for agency-wide audits in the *Provider Agency Audit Guide* (online at www.dhfs.state.wi.us/grants) for all other agencies, including:
   - Non-profit organizations, whether or not they also need to have audits in accordance with OMB Circular A-133.
   - For-profit organizations.
   - Local governments that do not need to have audits in accordance with OMB Circular A-133, and thus are not subject to the *State Single Audit Guidelines*.

4. The audit standards in this *Family Care Audit Guide*, which describes compliance requirements specific to the Family Care Program, supplementing the following sections in the department's audit standards:
   - The Compliance Requirements in Section 5 the *Provider Agency Audit Guide*.
   - The DHFS audit requirements in Appendix F435 of the *State Single Audit Guidelines*.

## 1.2 OMB Circular A-133 is not applicable

The department does not consider the Family Care Program to be federal financial assistance. Therefore, the requirements of OMB Circular A-133 "Audits of States, Local Governments, and Non-Profit Organizations" are not applicable based on funding for the Family Care Program. However, agencies must have A-133 audits if they meet the requirements for such an audit based on funding other than the Family Care Program.

## 1.3 Entities operated by local governments

If a Family Care entity is governed by a single county, the audit of the Family Care entity may be a part of the county's annual audit, which is performed in accordance with the *State Single Audit Guidelines* and the *Family Care Audit Guide*. The Family Care Program is the equivalent of a named state major program for purposes of audit testing.

The *State Single Audit Guidelines* identify certain programs to be named state major or Type A programs, including several which might be administered through Family Care:

- Community Options Program (designated major)
- Case Management Agency Providers (designated Type A)
- Community Integration Program II/Community Options Program Waiver (designated Type A)
- Community Integration Program I, Brain Injury Waiver, and Community Supported Living Arrangements Waiver (a program cluster) (designated major)

- Medicaid Personal Care Program (designated Type A)
- Community Services Deficit Reduction Benefit (designated Type A)

The audit requirements in the *State Single Audit Guidelines* for these programs remain in effect as long as the programs continue to operate, even in a county that also is operating a Family Care Management Organization.

## 1.4 Effective date

The *Family Care Audit Guide* is to be used for audits of Resource Centers and Care Management Organizations participating in the Family Care Program for years ended on or after December 31, 2002.

## 1.5 Updates to the Family Care Audit Guide

The *Family Care Audit Guide* and all updates are on line at www.dhfs.state.wi.us/grants. Auditors should check for updates at this website as part of audit planning.

## 1.6 When the audit report is due

The audit report is due to the department within 180 days of the end of the agency's fiscal period. However, if the family care entity is audited as a part of a county audit, the deadline for the family care entity's audit is the deadline for the county audit, which is nine months from the end of the fiscal period.

## 1.7 What to include in the audit report

At a minimum, the audit report materials that an agency sends to the department shall include the following elements:

- The auditor's opinion on the financial statements of the agency.
- The financial statements of the agency and the notes thereto.
- The auditor's report on the agency's compliance and internal controls based on the financial statement audit performed in accordance with *Government Auditing Standards*.
- Assurance that the audit was performed in accordance with the requirements of the *Provider Agency Audit Guide* or the *State Single Audit Guidelines*. This assurance may be in the form of a separate report on compliance with the requirements of the *Provider Agency Audit Guide* or the *State Single Audit Guidelines* or reference to the appropriate document in the report on internal controls and compliance that is required for the audit performed in accordance with *Government Auditing Standards*.
- Assurance that the audit was performed in accordance with the requirements of the *Family Care Audit Guide.* This assurance may be in the form of a separate report on compliance with the requirements of the *Family Care Audit Guide* or reference to the guide in the report on internal controls and compliance that is required for the audit performed in accordance with *Government Auditing Standards*.
- The schedule of findings and questioned costs.
- The schedule of prior year findings.

- The management letter (or similar document conveying auditors' comments issued as a result of the audit) or written assurance a management letter was not issued as a result of the audit.
- The agency's corrective action plan for all findings in the audit report and the management letter, if one was issued.

For Resource Centers and CMOs operated by counties, these report elements may be incorporated into the respective report elements for the county's audit report.

## 1.8 Where to send the audit report

Send two complete copies of the audit report to the Department of Health and Family Services at the following address:

Office of Program Review and Audit
Department of Health and Family Services
1 West Wilson Street, Room 951
P.O. Box 7850
Madison, WI 53707-7850

## 1.9 Questions on audit requirements

Questions on audit requirements for the Family Care Program can be referred to the department at the address listed above or by contacting the department by phone or e-mail:

| | |
|---|---|
| Contact person: | Sarah Houfe |
| Telephone: | (608) 261-8879 |
| Email: | houfesj@dhfs.state.wi.us |

# 2 Compliance Requirements for Resource Centers

The following overview of Resource Centers is from the department's website at http://www.dhfs.state.wi.us/LTCare/INDEX.HTM:

Aging and Disability Resource Centers offer "one-stop shopping" to the general public with a focus on issues affecting older people, people with disabilities, or their families. These Centers are welcoming and convenient places to get information, advice and access to a wide variety of services. As a clearinghouse of information about long term care, they will also be available to physicians, hospital discharge planners, or other professionals who work with older people or people with disabilities. Services will be provided through the telephone or in visits to an individual's home. Detailed descriptions of the services the Resource Centers provide are contained in the Resource Center Contract (on line at http://www.dhfs.state.wi.us/LTCare/pdf/RCContract.pdf). A more general description of the services they provide follows:

- **Information and Assistance.** Providing information to the general public about services, resources and programs in areas such as: disability and long term care related services and living arrangements, health and behavioral health, adult protective services, employment and training for people with disabilities, home maintenance, nutrition and Family Care. Resource Center staff will provide help to connect people with those services and to also apply for SSI, Food Stamps and Medicaid as needed.

- **Long Term Care Options Counseling.** Offering consultation and advice about the options available to meet an individual's long term care needs. This consultation will include discussion of the factors to consider when making long term care decisions. Resource Centers will offer pre-admission consultation to all individuals entering nursing homes, CBRFs, adult family homes and residential care apartment complexes to provide objective information about the cost-effective options available to them. This service is also available to other people with long term care needs who request it.
- **Benefits Counseling.** Providing accurate and current information on private and government benefits and programs**.** This includes assisting individuals when they run into problems with Medicare, Social Security, or other benefits.

- **Emergency Response.** The Resource Center will assure that people are connected with someone who will respond to urgent situations that might put someone at risk, such as a sudden loss of a caregiver.

- **Prevention and Early Intervention.** Promote effective prevention efforts to keep people healthy and independent. In collaboration with public and private health and social service partners in the community, the Resource Center will offer both information and intervention activities that focus on reducing the risk of disabilities. This may include a program to review medications or nutrition, home safety review to prevent falls, or appropriate fitness programs for older people or people with disabilities.

- **Access to the Family Care Benefit.** For people who request it, Resource Centers will conduct a functional and financial eligibility determination to assess the individual's level of need for the Family Care benefit. Once the individual's level of need is determined, the Resource Center will provide advice about the options available to him or her – to enroll in Family Care, stay in the Medicaid fee-for-service system (if eligible), or to privately pay for services. If the individual chooses Family Care, the Resource Center will enroll that person in the Care Management Organization (CMO). The level of need determined by the Resource Center will also trigger the monthly payment amount to the CMO for that person.

Unless otherwise indicated, all compliance requirements discussed in this section are based on the standard contract between the Resource Center and the Department for calendar year 2002. The auditor should refer to the actual contract and any supplementary materials when assessing how a requirement applies to a particular Resource Center.

## 2.1 Accounting Requirements/Annual expenditure report

*Compliance Requirement:* The standard Resource Center contract for calendar year 2002 requires, in Article V, Section B, Paragraph 1, the Resource Centers to maintain uniform double entry, full accrual accounting systems in accordance with Generally Accepted Accounting Principles (GAAP). In Article IV, Section H, Subsection 1, the Resource Centers are required to submit an annual expenditure report describing the amount of funds spent on each Resource Center function and the use of funds by categories as determined by the Department. Categories are identified on the report form.

*Suggested Audit Procedures:* Sample Resource Center transactions and review accounting policies and procedures to determine compliance with the Resource Center contract and GAAP. Review the annual expenditure report to determine accuracy and consistency with financial reports.

## 2.2 Medicaid cost center for information and assistance activities

*Compliance Requirement:* The standard Resource Center contract for calendar year 2002 requires the Resource Center to maintain what can be termed an Information and Assistance Program Cost Center in order to claim Medicaid Funds. Article VI, Section B provides, in its entirety, as follows:

> In order to claim Medicaid funds, each Resource Center shall establish a separate information and assistance program cost center in the accounting records. This cost center will include all costs related to performing information and assistance **except** the following:
>
> - Activities funded with other federal dollars such as Older Americans Act funds or Medicaid Administrative Pass Through (MAPT) funds.
> - Activities that are service activities billable to other sources such as Medicaid Case Management.

Costs charged to the Information and Assistance Program Cost Center are based on 100% time reporting. The time reporting should be captured in the Time Report Section of the monthly Information and Assistance Reports that the Resource Center contract requires, in Article IV, Section H, Subsection 1, the Resource Center to submit to the Department.

The Information and Assistance Program costs are reported to the State via the Community Aids Reporting System (CARS) on profile number 1401. The Department then determines the Medicaid portion of the costs by multiplying the reported eligible Information and Assistance Program costs by a certain percentage. The percentage that the Department uses is based on the ratio of the number of the elderly and disabled who are on Medicaid in the county in which the Resource Center is operating to the total number of the elderly and disabled in that county. The calculated Medicaid portion of the costs are then allocated to profile 1402 for reimbursement to the Resource Center.

*Suggested Audit Procedures:*

- Compare the costs reported in the CARS reports on profile number 1401 for Information and Assistance Program with the time reported in the Time Report Section of the monthly Information and Assistance Reports in order to determine whether the costs claimed in the CARS reports seem accurate and complete. Note that costs reported on CARS may include items such as mileage reimbursement and supplies that will not be reflected on a time report. (The Department can provide copies of the monthly Information and Assistance Reports to auditors should they need such copies.)

- Ensure that expenditures reported on CARS profile 1401 were not also reported on CARS profile 1400.

- Review the time reported in the Time Report Section of the monthly Information and Assistance Reports to make sure that this time does not include activities funded in whole, or in part with federal dollars which may include, but are not limited to, those available through the Older Americans Act or Medicaid Administrative Pass Through (MAPT).

## *2.3 Functional screen federal financial participation (FFP)*

*Compliance Requirement:* Resource Centers operating in counties that also operate Care Management Organizations are eligible to receive federal payments to offset 50% of the costs of administering functional screens if those screens are used to determine an individual's eligibility for the Medicaid program. For eligible entities, a Resource Center Functional Screen Addendum is attached to the standard contract for 2002. It provides in part, as follows:

> …These funds will be used to administer functional screens at the Resource Center. The functional screen must be used to determine an individual's functional eligibility for the family care benefit.
>
> Functional Screen Program costs include those identified in Attachment 1 to this Addendum and are limited to the salary, fringe benefit, and other costs directly attributable to the individual(s) administering functional screens, plus indirect costs that are applied in accordance with a DHFS-approved cost allocation plan. Functional Screen Program

activities include those activities necessary to schedule an appointment to administer the functional screen on an individual, travel to and from the appointment scheduled with the individual, interview the individual and administer the functional screen on him or her, make any collateral contacts with the individual's relatives, friends, health care providers or other individuals in order to verify information obtained about the individual through the administration of the functional screen, obtain and review medical records or other documents needed to verify information obtained about the individual through the administration of the functional screen, complete the paperwork and data entry work required to make the functional screen a record stored in a filing system or data base maintained by the Resource Center, and complete the paperwork and data transmission work needed to enable the Resource Center to transmit all or part of the functional screen to the Department, the county economic support unit, a care management organization, or to any other agency of state or federal government that has a need, including a research need, to see all or part of the functional screen and is legally entitled to see all or part of the functional screen.

Costs of functional screens are reported on CARS profile number 1431.

*Suggested Audit Procedures:*

- Compare the authorized FFP hourly reimbursement rate with the actual costs per hour for performing screening activity. Compare number of screens administered and the time per screen with the figures reported to the Department. (The Department can provide this information to auditors.) Ensure reimbursement is taken only in connection with screens used to determine Medicaid eligibility.

- Ensure that expenditures reported on CARS profile 1431 were not also reported on CARS profile 1400.

# 3 Compliance Requirements for Care Management Organizations

The following overview of Care Management Organizations is from the department's website at http://www.dhfs.state.wi.us/LTCare/INDEX.HTM:

In addition to increasing access to services, a goal of Family Care is to improve the coordination of LTC services by creating a single flexible benefit for all long term care (LTC) services. Care Management Organizations will cover specific LTC services offered by Medicaid, as well as services in the Home and Community-Based Waivers and the very flexible Community Options Program benefit. For a list of the services that must be offered by CMOs, refer to the description of the long term care benefit package in the Health and Community Supports Contract (on line at http://www.dhfs.state.wi.us/LTCare/pdf/CMOcontract.pdf).

Pilot county Care Management Organizations (CMOs) will receive a per person per month payment to manage care for recipients who are living in their own homes, group living situations, or nursing facilities. CMOs will:

- Develop and manage a comprehensive network of long term care services and supports, and deliver some services directly through CMO staff.
- Conduct a comprehensive assessment of individual's needs, abilities, preferences and values with the consumer and family/guardian. The Care Management Team, consisting of at least a social service coordinator and registered nurse, the member, and informal supports jointly participate in completing a comprehensive assessment which looks at areas such as: activities of daily living, physical health, nutrition, autonomy and self determination, communication, and mental health and cognition.
- Design a care plan in partnership with the consumer, which is based on information gathered during the comprehensive assessment and is tailored to the individual's needs, preferences and outcomes.
- Be responsible for the quality of care and services consumers receive, and for continually improving the quality of care and services.
- Receive a monthly, per person payment for each enrollee based on functional need.

Unless indicated otherwise, all compliance requirements in this section are based on the standard contract between the department and CMOs. The auditor should refer to the actual contract and any supplementary materials when assessing how a requirement applies to a particular CMO.

## *3.1 Year-end financial statements/risk sharing*

*Compliance Requirement:* The Department will share losses and surpluses (hereafter **gain/loss)** with the CMO provided the CMO has elected this contract option, and only after the CMO has expended all Family Care revenues, including all CMO revenues, enrollee cost share and third party liability recoveries, and after both individual stop-loss adjustments and retrospective payment adjustments are made. Gain/loss are limited to gain/loss attributable to service costs and are defined as a percentage of CMO Revenues, to be calculated as follows:

The amount of gain/loss subject to sharing shall be determined by an independent financial audit that is based on the CMO's financial reports. To determine the gain/loss eligible for sharing, actual administrative costs, up to a maximum allowable cost, will be deducted from CMO Revenues. The remainder amount will then be the base upon which the CMO's gain/loss percentage is determined. "Maximum allowable administrative costs" will equal 20% of CMO revenues during the first full or partial year of CMO operation, and 15% of CMO revenue in the first renewal term.

The federal government will not share in gain/loss attributable to CMO members that are not eligible for Medicaid. The Department will compute the non-medicaid share of gain/loss by dividing non-medicaid member months by total member months for the period. The Department's risk sharing calculation spreadsheet is made available to each CMO.

*Suggested audit procedures:*

- Determine whether the CMO's estimates and adjustments for its IBNR meet the department's IBNR specification, which are available from the Family Care contact person.
- Provide an opinion on the method utilized by the CMO to estimate and subsequently adjust its IBNR. Provide a statement of how IBNR was adjusted to arrive at the estimate of liability used for risk sharing. IBNR specifications are available through the Family Care Program contact person.
- Based on enrollment and dis-enrollment records, verify the accuracy of reported member months for medicaid eligible and non-medicaid eligible members.

## 3.2 Client funds

*Compliance Requirement:* A CMO might act as a fiduciary for client funds. Wis. Statutes and the Social Security Administration provide guidance on the responsibilities of fiduciaries.

*Suggested Audit Procedures:* If the CMO has fiduciary responsibility for client funds, determine whether the CMO:

- Implemented adequate internal controls over client funds, such as segregation of duties for authorizing disbursement of client funds and disbursing those funds.
- Had written authorization from the client or the client's guardian, agent, or designated representative to hold the resident's funds.
- Segregated client funds from the CMO's funds.
- Maintained written records of the client's funds and provided reports of these funds to clients, guardians, agents, or designated representatives.

## 3.3 Cost sharing

*Compliance Requirement:* The CMO is responsible for collection of the member's monthly cost-share as determined by county Emergency Support (ES) staff, and to monitor the cost-share/spend down amounts of it's members. CMOs are required to report in a timely manner on HSRS any member cost-share that is collected.

*Suggested Audit Procedures:* Compare member cost-share requirements with amounts

collected. Compare cost-share receipts with amounts reported on HSRS.

## 3.4 Third party liability (TPL)

*Compliance Requirement:* The CMO shall actively pursue, collect and retain any monies from third party payers for services in the LTC benefit package to members except where the amount of reimbursement the CMO can reasonably expect to receive is less than the estimated cost of recovery. Records shall be maintained of all third party collections and reports shall be made quarterly to the Department.

*Suggested Audit Procedures:* Review CMO's TPL recovery procedures and practices. Compare recovered amounts with quarterly reports to the Department.

## 3.5 Payment to providers

*Compliance Requirement:* The CMO shall pay at least 90% of claims from subcontractors for services in the LTC benefit package that receive advance authorization from the CMO within 30 days of receipt of bill, and 99% within 90 days, except to the extent subcontractors have agreed to later payment.

*Suggested Audit Procedures:* Review a sample of subcontractor claims for pre-authorized services and compare them with para. C 3 on page 56 of the CY 2002 Health and Community Supports Contract.

## 3.6 Audits of service providers

*Compliance requirement:*
Wis. Stat. 46.036(4) requires audits of service providers which receive $25,000 or more in department funding for the purchase of care and services, unless the audit is waived by the department. The CMO may request the waiver based on the risk assessment process described in the *Provider Agency Audit Guide* (on line at www.dhfs.state.wi.us/grants). Audits, if required, must meet the department's standards in the *Provider Agency Audit Guide* or the *State Single Audit Guidelines.*

*Suggested audit procedures:*
For a sample of the CMO's contracts with service providers, determine whether the CMO:

- Followed the *Provider Agency Audit Guide* when deciding whether to require an audit and, if so, the kind of audit.
- Performed the monitoring that it had planned to rely on so it could waive an audit or require a lesser-scoped audit than the risk would have otherwise indicated.
- Has a written waiver of the audit requirement from the department for all audits that were waived.
- Collected all audits due to the CMO by 180 days of the provider's fiscal year end, unless an extension was authorized.
- Reviewed all audits to determine whether the audit met the applicable audit standards.
- Identified and resolved any issues in the audit that affected the CMO's contract with the

provider.

For CMOs that are operated by a county, the provisions in this section may be tested as part of the testing for the county's purchase of service function.

## *3.7 Capacity for financial solvency and stability*

The contract between the CMO and the department includes provisions for demonstrating that the CMO has capacity to assume the financial risks under the contract. The CMO's financial capacity consists of three components:

- Working capital
- Restricted reserve
- Solvency protection

*Compliance requirement(s):*
Working capital is the difference between current assets and current liabilities. A CMO's working capital shall not be less than 2% of the projected annual capitation payments from the department to the CMO for the period of the contract. The CMO shall include working capital as part of the monthly financial report that it provides to the department.

*Suggested audit procedure(s):*
Trace the current assets and current liabilities reported in the final monthly financial report and in one interim monthly financial report to the accounting records and supporting documentation to determine whether the CMO accurately reported these amounts to the department.

*Compliance requirement(s):*
Beginning on January 1, 2002, the CMO's restricted reserve account shall be a separately identifiable account in the chart of accounts. The initial minimum balance shall be the greater of $250,000 or 25% of the required minimum balance, calculated as follows:

- 8% of the first $5 million of annual capitation
- 5% of the next $5 million of annual capitation
- 3% of the next $10 million of annual capitation
- 2% of the next $30 million of annual capitation
- 1% of any additional annual capitation to a maximum required minimum balance of $2 million.

The CMO may make contributions to the account at any time to ensure that the balance reaches 50% of the required minimum balance by the end of the contract period. Any earnings on the restricted reserve account are to remain in the account until the balance reaches the required minimum balance. The CMO may not make disbursements from the restricted reserve account that take the balance below the required minimum balance, unless it has obtained prior approval from the department for the disbursement. The CMO shall report on the status of the restricted reserve account as part of the monthly financial report that it provides to department.

*Suggested audit procedure(s):*

- Determine whether the CMO maintained its restricted reserve account in a separately identifiable account in the chart of accounts.
- Determine whether the CMO had prior approval from the department for any disbursements from the restricted reserve account that brought the balance of the account below the required minimum balance.
- Trace the balances of the restricted reserve account reported in the final monthly financial report and in one interim monthly financial report to the accounting records and supporting documentation to determine whether the CMO accurately reported these amounts to the department.

*Compliance requirement(s):*

The CMO is required to provide evidence of solvency protection, which ensures the availability of liquid assets for continuity of care in event the CMO becomes insolvent. This solvency protection may take one of two forms:

1. The county can guarantee that the county is responsible for all financial obligations of the CMO. If the county guarantees responsibility and if the CMO has projected annual capitation payments in excess of $10,000,000, the county must establish a separately identifiable reserve account on the chart of accounts in the amount of $250,000.
2. The CMO may deposit funds into an individual pledged solvency account at a rate to ensure that the balance of the account reached 50% of the required account balance by December 31, 2002. The required account balance is:

    - 10% of the first $5 million of annual capitation (minimum balance of not less than $400,000)
    - 5% of the next $5 million of annual capitation
    - 2.5% of the next $10 million of annual capitation
    - 1% of any additional capitation to a maximum required balance of $2 million

    The individual pledged solvency account may be maintained by the department or by the CMO. If the account is maintained by the CMO, it must be a restricted account.

*Suggested audit procedure(s):*

- If the CMO chose the first option, determine whether it set aside $250,000 in a separately identifiable reserve account on the chart of accounts.
- If the CMO chose the second option and if it maintained the individual pledged solvency account (as opposed to the department maintaining this account), determine whether the account is a restricted account.
- If the CMO chose the second option and if it maintained the individual pledged solvency account (as opposed to the department maintaining this account), determine whether the CMO made contributions to reach 50% of the required minimum account balance.